INSTRUCTIONS
ADVANCED PRACTICE PROFESSIONAL NURSE (APPN)
2007-2009 RENEWAL APPLICATION

- In order to renew your Advanced Practice Professional Nurse License in the category of Certified Nurse-Midwife (CNM), Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), or Registered Nurse Anesthetist (RNA), you must also renew your professional nurse (RN) license *(unless your primary state of residence is in a Compact State)*. Renewal applications may be submitted together with one check or money order to cover the APPN renewal fee ($90) and the RN renewal fee ($90), or either form may be submitted individually, or your RN license can be renewed on-line and your APPN submitted via paper,. (APPN applications are also available for download from the Board's website at www.state.id.us/ibn click on "Licensing Information".) Applications post-marked after August 31, 2007, will be assessed an additional $35.00 late fee. Both applications must be completed and signed to avoid a delay in processing.

- If your name and/or address on the renewal application are not correct, print the correct information on the appropriate line. (Name Changes must be accompanied by copy of marriage license, divorce decree, other legal document, or Notarized Affidavit available from this office.)

- Complete questions 1 through 12. (Questions 8 and 9 are voluntary disclosure information and responses are optional.)

- Enclose a copy of your current national certification(s). If you are not currently certified, and were approved as a nurse practitioner prior to July 1, 1998 you are exempt from this requirement (IDAPA 23.01.01.300.06.)

- Complete the enclosed Continuing Education Activities Report (or provide the same information on a form of your choice). Do NOT submit copies of validation materials regarding the continuing education unless instructed to do so.

- The Criteria for APPN Continuing Education were adopted by the Board in February 1999. The criteria require that:
    a. The provider of continuing education must be:
        1) a nationally recognized nursing organization; or
        2) an accredited academic institution; or
        3) a provider of continuing education recognized by another board of nursing; or
        4) a provider of continuing education recognized by a regulatory body of another discipline (e.g. CME, CPE, telemedicine); or
        5) approved by the Board of Nursing.
    b. Content must be related to the practice of the APPN.
    c. Acceptable CE activities will include activities identified in 'a' above and in addition, may include:
        1) participation as the presenter of approved continuing education programs (presenting continuing education may not be your primary job responsibility);
        2) participation in related professional activities including but not limited to research, published material, teaching, peer review, precepting and professional auditing. (A total of no more than three (3) contact hours may be awarded for related professional activities.)
    d. Evidence of documentation of completion of the continuing education activity. (e.g. transcript, certificate, verification letter, etc.)

- Over -

IDAHO BOARD OF NURSING
PEER REVIEW POLICY
Adopted 11/11/04

Peer Review is:

- **A process that measures on-going practice competency of the advanced practice nurse (APPN*).*** *Peer review is the "systematic process" by which one assesses, monitors and makes judgments about the quality of care provided to patients by other peers as measured against established standards of practice" (ANA, 1983)*
- **Performed by a licensed APPN, Physician, PA or other professional certified by a recognized credentialing organization.** *It is important that the person that performs the review is knowledgeable of the standards of care required by the clients seen. A peer is a health professional with similar but not necessarily identical training or experience*
- **Focused on a mutual desire for quality of care and professional growth incorporating attitudes of mutual trust and motivation.** *The overall purpose is to improve client outcomes by encouraging nurse provider competency. It should have the positive effect of stimulating personal and professional development and challenge the nurse to think critically about his practice.*

Peer Review shall:

- **Reflect nationally recognized standards of care.**
- **Provide evidence of competence** . *It should focus on a mutual desire for quality of care and professional growth, incorporating attitudes of mutual trust and motivation. It should not be used to take privileges or personnel actions or as an annual employment review. Participants need to agree to be objective and to give and take constructive evaluation.*
- **Include one or more of the following peer review processes:**
    - **Clinical rounds**
    - **On-site peer collaboration**
    - **Retroactive records review**
    - **Other appropriate processes as defined by the APPN and approved by the Board**

  It is important to establish how the process will be done. A written policy, contract or verbal agreement will identify how this will be done. If the process is clinical rounds, than how often will this be done and how many clients will be reviewed? An on-site peer collaboration or retroactive records review process should define how often it will take place and the number of client charts that will be reviewed.
- **Provide evidence that issues identified in the peer review process have been/are being appropriately addressed.** *The process should be able to facilitate early identification of quality issues or concerns. A record of review with issues that were identified should be available. Discussion of forms and a best practice model are available on the Board web site at www2.idaho.gov/ibn.*

Completion of a peer review process will be evidenced by:

- **Signature of the attestation statement at the time of biennial licensure renewal.**
- **APPN supporting documentation at the request of the Board, e.g., signed peer statement, reports/records, peer contract, institutional policy, etc.**
- **Demonstration/documentation available at on-site practice**

Board Policy in BOLD type

- **Affix your signature to the application.**

CE_____ APPN #_____
AUD_____ RN #:_____

IDAHO BOARD OF NURSING
PO Box 83720 ♦ Boise, Idaho 83720-0061 ♦ (208) 334-3110 ext. 25

RENEWAL APPLICATION
ADVANCED PRACTICE PROFESSIONAL NURSE (APPN)

For office use only
Certificate No. _____
Check ❒ Cash/MO ❒
Date Rec'd_____
RN License Issued_____
Approval_____
Date Issued_____

Mail completed application with the $90.00 fee to the Board of Nursing by August 31, 2007. (Mailing of licenses accompanied by personal checks will be held for ten (10) days to allow for processing of the check by the bank.) The amount due will be $125.00 if the application is post-marked after August 31, 2007. ***In order to renew your Advanced Practice Professional Nurse License, you must also renew your professional nurse (RN) license (unless residing in Compact state). Applications will be returned if incomplete or the incorrect fee is submitted.***

Indicate changes in name and/or address:

(Name Changes must be accompanied by marriage license, divorce decree, other legal document, or Notarized Affidavit available from this office.)

1. Category of Licensure: ❒ Certified Nurse-Midwife ❒ Clinical Nurse Specialist ❒ Nurse Practitioner ❒ Registered Nurse Anesthetist

2. I am practicing as an APPN: ❒ Full-time ❒ Part-time, or I am: ❒ Not Practicing

3. I am practicing: ❒ In-State ❒ Out-of-State

4. Primary Practice Setting:
   - ❒ Health Care Institution (hospital, nursing home, etc.)
   - ❒ Government outpatient clinic
   - ❒ Private outpatient clinic
   - ❒ Physician–owned practice
   - ❒ Non-physician-owned practice
   - ❒ Other (specify)_____

5. Specialty Areas of APPN Practice: *(mark all that apply):*
   - ❒ Acute Care ❒ Adult Care ❒ Anesthesia ❒ Family Practice ❒ Gerontology
   - ❒ Midwifery ❒ Neonatology ❒ Oncology ❒ Pediatrics ❒ Psych/Mental Health
   - ❒ School Nsg ❒ Women's Hlth ❒ Critical Care/CCU ❒ Other (specify)_____

Continued on reverse

continued…

6. I currently prescribe: ❒ legend drugs ❒ scheduled drugs

7. I currently dispense: ❒ legend drugs ❒ scheduled drugs

8. *Gender: ❒ Female ❒ Male

9. *Ethnicity:
❒ Caucasian ❒ African American/Black
❒ Hispanic ❒ American Indian/Alaska Native
❒ Asian/Pacific Islander ❒ Multi-Racial
❒ Other_____

*Voluntary disclosure information – response optional

10. Please [**X**] the appropriate box(es) pertinent to your practice:

❒ I have completed thirty (30) contact hours of continuing education that meet Board established criteria during the renewal period.

❒ I have completed ten (10) contact hours of approved pharmacology-related continuing education during the renewal period.

❒ I have practiced a minimum of two hundred (200) hours of advanced practice professional nursing during the renewal period.

11. **CNM, CNS, NP only**:

❒ I have participated in a Peer Review process that meets Board-established criteria.

12. I have attached a copy of my current APPN national certification(s):
❒ Yes
❒ No - Please explain below:

My signature affixed below attests that the information provided in this application for renewal of my advanced practice professional nurse licensure is true and correct to the best of my knowledge.

Signature_____ Date_____

ATTENTION: CERTIFIED REGISTERED NURSE ANESTHETISTS

Administrative rules of the Board (IDAPA 23.01.01.300.03) indicate that licensure renewal is dependent on, among other things, "documentation of thirty (30) contact hours of continuing education during the renewal period". The rules indicate further that continuing education may be that required for renewal of national certification if documentation is submitted confirming the certifying organization's requirement is for at least thirty (30) contact hours.

The Board is aware that the AANA requires completion of more than the required number of hours every two years for certification renewal, and that the renewal cycle may be calculated on either an even- or odd-numbered year biennial cycle. The Board agrees that the AANA's requirement for certification renewal is consistent with the administrative rule**. Therefore, submission of a copy of your current AANA certificate is sufficient evidence to meet this requirement. On the "Continuing Education Activities Form", indicate your name, APPN license number and the expiration date of your AANA certification only. It is not necessary to complete the form as indicated.**

Please note: If you are selected for a random audit, you will be required to submit documentation (transcripts, certificate, etc.) that verify completion of continuing education during the AANA renewal cycle.

IDAHO CODE 54-1411 (2) does not require the process of Peer Review for Registered Nurse Anesthetists.

IDAHO BOARD OF NURSING
ADVANCED PRACTICE PROFESSIONAL NURSE
CONTINUING EDUCATION ACTIVITIES REPORT

FROM 9/2005 TO 8/2007

NAME_____

IDAHO APPN License number: CNM_____ CNS_____ NP_____ RNA_____

ADDRESS_____

_____

Advanced Practice Professional Nurse License Renewal: Rule 23.01.01.300.03.	RENEWAL OF LICENSURE IS DEPENDENT UPON documentation of 30 contact hours of continuing education during… [the last] two year period
Authorization Renewal: Rule 23.01.01.315.02.b.	RENEWAL OF PRESCRIPTIVE AUTHORITY IS DEPENDENT UPON completion of ten (10) contact hours of approved pharmacology-related continuing education in the twenty-four (24) months immediately preceding application for renewal. Hours may be part of the thirty (30) required hours (above).
DEFINITIONS:	CONTINUING EDUCATION – consists of planned learning experiences designed to maintain and update knowledge, skills, and attitudes for the enhancement of practice. CONTACT HOURS = equal clock hours.

THIS REPORT MAY BE AUDITED. IF SELECTED FOR AUDIT, YOU MAY BE ASKED TO SUBMIT DOCUMENTATION OF COMPLETION OF INDICATED CONTINUING EDUCATION. (Attach additional pages if necessary.)

DATE	NAME OF PROGRAM	SPONSOR	Contact Hours	Pharmacolgy-Related Hours

Idaho Board of Nursing
APPN AUDIT - 2007
Phase I

Please complete the following form as part of your renewal application and return with your completed application in the envelope provided.

Name:_____
Idaho APPN License Number: CNM_____ CNS_____ NP_____RNA_____
Primary Idaho County Where You Work:_____ Out of State_____
Indicate your National Specialty Certification(s):
☐ ANP ☐ CNM ☐ CRNA/RNA ☐ FNP ☐ NNP ☐ PNP ☐ WHCNP
☐ CNS Speciality:_____ ☐ Other - specify_____

1. Which of the following describes your relationship(s) with physician(s)? ***(Please check all that apply.)***
   _____I consult daily with physician(s) on site.
   _____I contact various physicians by specialty for consultation and collaboration, as needed.
   _____I call for advice PRN.
   _____Physician does in-house chart reviews.
   _____I call physician(s) at least one time per week.
   _____I have a signed contract with a physician(s).

2. Check the setting which describes where you practice the majority of time:
   _____Hospital
   _____Clinic, For example: Emergent Care, Specialty (diabetes, rehab, etc.)
   _____Public or Private Educational Institution
   _____Public Health, For example: STD/Family Planning, Immunizations, Education (wellness, cardiac rehab, etc.)
   _____Home Care
   _____Physician Office
   _____Long Term Care Facility
   _____Other, specify:_____

3. Which practitioners have you collaborated with in the past year? ***(Please check all that apply.)***
   _____Physician _____Physical Therapist
   _____Occupational Therapist _____Speech Therapist
   _____Dietitian _____Social Worker
   _____Counselor _____APPN
   _____Pharmacist _____Other, specify:_____

4. Are there other health care providers in your practice setting?
   Yes_____ No_____
   If Yes – I have collaborative relationships with the following health care providers:

   ☐ APPN ☐ MD ☐ PA ☐ RPh ☐ Other_____

5. Which of the following do you prescribe? ***(Please check all that apply.)***
   _____Legend Medications
   _____Controlled Substances
   _____Other, specify _____
   _____ None

6. Including samples, which of the following medications do you dispense?
   (Please check all that apply.)
   _____Legend Medications _____Controlled Substances/Narcotics, Schedule**:**
   _____ II_____III _____IV _____V

7. Indicate if you have clients on the following reimbursement programs:

   _____Medicare _____Medicaid _____Private Insurance _____ Other _____Uninsured